

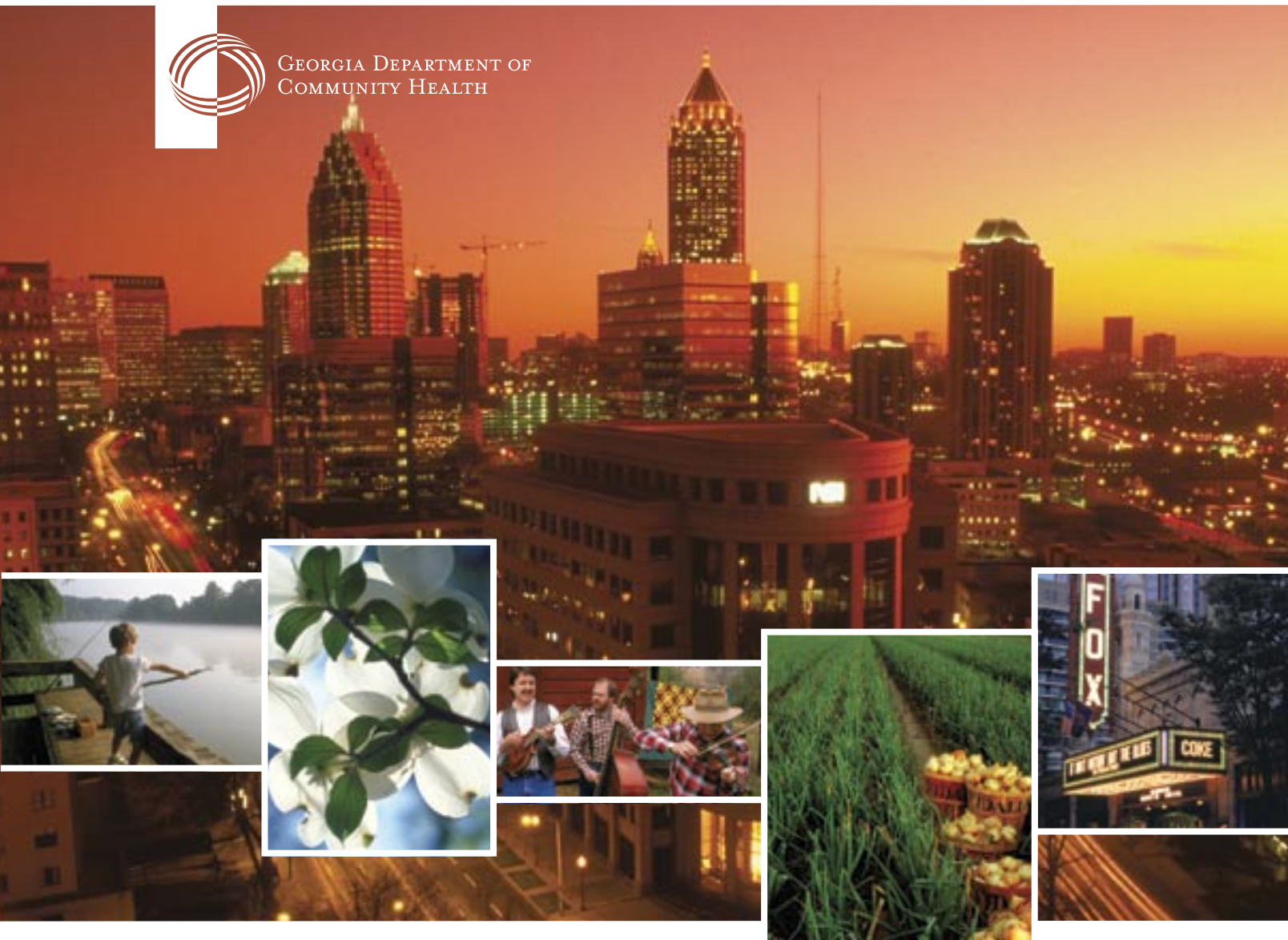
NEW EMPLOYEE

State Health Benefit Decision Guide

for January 1, 2006 – December 31, 2006



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH



**Important Information
Please Read**

PHONE NUMBERS/CONTACT INFORMATION

State Health Benefit Plan (SHBP): **www.dch.georgia.gov**

PPO, PPO CCO, Indemnity:

Member Services	877-246-4189 TDD 800-545-6751 www.myuhc.com/groups/gdch
Pharmacy Information (ESI)	877-650-9342 TDD 800-842-5754

HDHP:

Member Services and Pharmacy	877-246-4195
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HMOs:

BlueChoice	800-464-1367 TDD 404-842-8073	www.bcbsga.com
Cigna	800-564-7642	www.cigna.com
Kaiser Permanente	800-611-1811	www.kaiserpermanente.org
United Healthcare	866-527-9599 TDD 800-955-8770	www.myuhc.com
TRICARE Supplement:	800-638-2610 ext. 255	www.asitrisuppga.com
All Options: Eligibility	404-656-6322 or 800-610-1863	

If you enroll for health insurance coverage under the State Health Benefit Plan (SHBP), you should receive a Summary Plan Description (SPD) from your Human Resources Department. This SPD reflects Plan benefits as of January 1, 2006. Please keep your Summary Plan Description (SPD) for future reference. If you are disabled and need this information in an alternative format, call the TDD Relay Service at (800) 255-0056 (text telephone) or (800) 255-0135 (voice) or write the SHBP at P.O. Box 38342, Atlanta, GA 30334.

Photos on the cover courtesy of the Georgia Department of Economic Development.

STATE BENEFIT HEALTH PLAN

The Georgia Department of Community Health, which administers the State Health Benefit Plan, (SHBP), continually seeks to offer high-quality, affordable health coverage. Keep in mind, however, that you are the manager of your healthcare needs, and in turn, must take the time to understand your Plan benefit choices in order to make the best decisions for you and your family.

Let's start by talking about how the SHBP works. It is a self-funded plan, which means that all expenses are paid by employee premiums and employer funds. Approximately 95% of the premium goes directly to pay healthcare claims and 5% goes toward administering the Plan.

What can you do to help manage your healthcare costs?

Understand Your Options – compare all Plan Options, considering both the premium and out-of-pocket costs that you may incur. Web site and phone numbers are listed on the inside of the front cover of the Decision Guide if you need more information.

Consider Enrolling in a Healthcare Spending Account (HCSA) – A HCSA helps you save tax dollars, approximately 26–45% depending on your tax situation. By electing to use a HCSA, you may set aside up to \$5,040 annually to cover health-related treatment for yourself and your dependents. Eligible expenses include deductibles, co-payments, over-the-counter items for medical purposes and costs for certain procedures not covered under your health plan. The benefit of this account is that you are able to pay for these out-of-pocket costs with tax-free dollars! Contact your Benefit Coordinator for more information.

Become a More Proactive Consumer of Healthcare – Most people do not realize how much their treatments, medicines and tests cost.

Steps you can take include:

- Keep a list of all medications you take
- Shop in-network providers and pharmacies
- Find out what your drugstore charges for a drug, not just the co-payment
- Use generic medicines whenever possible
- Make sure all procedures are pre-certified, if required
- Make sure you get the results of any test or procedure
- Understand what will happen if you need surgery
- Check your Explanation of Benefits (if provided under your plan option) and if something does not make sense or seems to cost too much, ask your provider about it.

These and other steps you take will help manage healthcare expenses, reduce your out-of-pocket costs and those of the Plan. In addition, these steps will help in keeping premium costs down.



People who do not understand their health coverage pay more, according to the American Medical Association. To help you better understand your Plan and save your healthcare dollars, we have prepared a few points for you to consider.

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GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Tim Burgess, Commissioner

Sonny Perdue, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.communityhealth.state.ga.us

November 7, 2005

MEMORANDUM

TO: All Members of the State Health Benefit Plan

Under a federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain notices must be provided to you. This memo will serve as notice to you related to the surcharge for tobacco use that the Plan will charge for coverage beginning January 1, 2006.

Under HIPAA, group health plans may not discriminate on the basis of “health status.” However, the law also permits state and local government employers that sponsor health plans to elect to exempt a plan from this requirement for any plan that is “self-funded” by the employer, rather than provided through a private health insurance policy. The Department of Health and Human Services considers tobacco use to be a “health status.” Therefore, the self-funded options under the SHBP have opted out of this requirement for the plan year January 1, 2006, through December 31, 2006. The election may be renewed for subsequent plan years. The purpose of this exemption is to enable the SHBP to comply with federal law in applying the tobacco use surcharge.

Therefore, this notice informs all members of the self-funded options of the State Health Benefit Plan of the Plan’s election to be exempt from the following provision:

Prohibitions against discriminating against individual participants and beneficiaries based upon health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The exemption and this notice do not change your eligibility, your benefits, or your premiums, other than to apply the surcharge for tobacco use if applicable.

HIPAA also requires the Plan to provide covered employees and dependents with a “certificate of creditable coverage” when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan because you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer’s health plan, or if you wish to purchase an individual health insurance policy. You may obtain the certificate of creditable coverage upon request.

If you have any questions about this notice, you may contact:

State Health Benefit Plan
Attn: Surcharge
P. O. Box 38342
Atlanta, Georgia 30334

Equal Opportunity Employer

ELIGIBILITY INFORMATION

All SHBP options have the same eligibility requirements except the TRICARE Supplement (see page 13). A summary is listed below.

For You

You are eligible to enroll yourself and your eligible dependents for coverage if you are:

- **A full-time employee of the State of Georgia, the General Assembly, or an agency, board, commission, department, county administration or contracting employer that participates in the SHBP, as long as:**

- You work at least 30 hours a week consistently, and
- Your employment is expected to last at least nine months.

Not Eligible: Student employees or seasonal, part-time or short-term employees.

- **A certified public school teacher or library employee** who works half-time or more, but not less than 17.5 hours a week.

Not Eligible: Temporary or emergency employees.

- **A non-certified service employee of a local school system** who is eligible to participate in the Teachers Retirement System or its local equivalent. You must also work at least 60% of a standard schedule for your position, but not less than 20 hours a week.

- **An employee who is eligible to participate in the Public School Employees' Retirement System** as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated. You must also work at least 60% of a standard schedule for your position, but not less than 15 hours a week.

- **A retired employee of one of these listed groups** who was enrolled in the Plan at retirement and is eligible to receive an annuity benefit from a state-sponsored or state-related retirement system. See the SPD for more information.

- **An employee in other groups** as defined by law.



*TRICARE covers full-time students to age 23. To cover your full-time student after age 23 to age 26, you must select another SHBP option during the Open Enrollment Period prior to your dependent reaching age 23. A full-time student reaching age 23 is not a qualifying event to change options.



NOTE: Ineligible dependent determination does NOT allow a refund of premium or a change to single coverage. Dependent eligibility cannot be determined until the subscriber presents proper documentation to SHBP. Please review eligibility requirements before selecting family coverage.



The member's social security number **MUST** be written on each document.

For Your Dependents

Eligible dependents are:

- **Your legally married spouse**, as defined by Georgia Law.
- **Your never-married dependent children who are:**
 - 1 **Natural or legally adopted children under age 19**, unless they are eligible for coverage as employees. Children that are legally adopted through the judicial courts become eligible only after they are placed in your physical custody.
 - 2 **Stepchildren under age 19 who live with you** at least 180 days per year and for whom you can provide documentation satisfactory to the Plan that they are your dependents.
 - 3 **Other children under age 19** if they live with you permanently and legally depend on you for financial support—as long as you have a court order, judgment or other satisfactory proof from a court of competent jurisdiction.
 - 4 **Your natural children, legally adopted children or stepchildren who were covered under the SHBP before age 19 from categories 1 and 2 above** who are physically or mentally disabled prior to reaching age 19 and who depend on you for primary support may continue their existing Plan coverage past age 19.
 - 5 **Your natural children, legally adopted children, stepchildren or other children ages 19 through 25 from categories 1, 2, or 3 above** who are registered Full-time Students* at fully accredited schools, colleges, universities or nurse training institutions and, if employed, who are not eligible for a medical benefit plan from their employer. The number of credit hours required for Full-time Student status is defined by the school in which the child is enrolled.

In order to cover a spouse or dependent under the Plan, you must provide documentation. The Plan requires:

- **Spouse:** A copy of your certified marriage certificate or a copy of your most recent Federal Tax Return (filed jointly with spouse) including legible signatures for you and your spouse with financial information blacked out.
- **Natural or Student Child:** A copy of the certified birth certificate listing the parents by name. Birth cards without the parents' names are not acceptable.
- **Stepchild:**
 - 1 A copy of the certified birth certificate showing your spouse is the natural parent; and
 - 2 A copy of the certified marriage certificate showing the natural parent is your spouse; and
 - 3 A notarized statement that the dependent lives in your home at least 180 days per year.

GENERAL INFORMATION

How to Enroll

If you're eligible to participate in the SHBP, you become a member by enrolling either:

- As a new hire, within 31 days of your hire date. If you join the SHBP during that first 31-day enrollment opportunity, your coverage will go into effect on the first day of the month after you complete one full calendar month of employment. See your personnel/payroll office for instructions on how to enroll.
- As a result of a qualifying event. See When Are Changes Allowed? on page 7 of this guide for more details.

If you elect to decline SHBP coverage, you must complete a Declination Form, available from your personnel/payroll office, and file it within 31 days of your hire date.

Before making your selection, you should be aware that SHBP charges a Tobacco and Spousal Surcharge. A \$40 tobacco surcharge will be added to your monthly premium if you or any of your covered dependents have used tobacco products in the previous twelve months. A \$30 spousal surcharge will be added to your monthly premium if you have elected to cover your spouse and your spouse is eligible for coverage through his/her employment but chose not to take it. If your spouse is eligible for coverage with SHBP through his/her employment, the spousal surcharge will be waived.

You will automatically be charged the surcharge if you fail to answer all questions concerning the surcharges. The surcharge will apply to your premium until the next Plan year.

If you decide to become a SHBP member, you will have two major choices to make:

- **Your coverage option** – PPO, PPO CCO, Indemnity, HMO or HMO CCO, HDHP, HDHP CCO, or TRICARE Supplement; and
- **Your coverage type** – Single or Family coverage. For details on Single and Family coverage, see your SPD.

**! VERY IMPORTANT:
DEPENDENTS MUST BE
VERIFIED PRIOR TO THEIR
COVERAGE EXPIRATION DATE**
Continued Coverage for Students,
Disabled Children and Legal
Children

- Recertification must be received before coverage expiration date.
- The dependent will not be eligible after the expiration date, if the documentation is not received before this coverage expires. You may add the dependent during the next Open Enrollment period.

! It is important that you notify us if you have other group coverage to prevent incorrect processing of any claims. For further information about COB rules, refer to the SPD.

! A new employee's PEC limitation period begins the first day of the month he/she was hired.

Health Benefit Cost Estimator

Choosing the right health plan is an important decision and the SHBP is providing a Plan Cost Estimator (PCE) tool to assist you. The PCE offers you a simple way to help determine which option is best for you and your family. This online tool lets you compare how your out-of-pocket expenses may vary under the different health plan options available to you.

You can use the PCE to review cost information for prescriptions, anticipated tests and procedures and, if offered, determine how much to contribute to your Flexible Spending Account (FSA). The information provided by PCE is not meant to be an endorsement of any particular health plan. The service is offered only to help you compare your estimated expenses across each health plan option.

Access the link to the PCE tool at the DCH Web site www.dch.georgia.gov and click on "How Do I?" and then click on "Find Health Benefit Information as a New Hire or Transfer".

What Happens if I Have Other Insurance?

You or your covered dependents may have medical coverage under more than one plan. In this case, the Plan's coordination of benefits (COB) provisions apply.

When SHBP benefits are coordinated, the Plan does not pay more than 100% of the Plan's allowed amount. Non-covered services or items, penalties and amounts balance billed are not part of the allowed amount and are the subscriber's responsibility.

Pre-existing Conditions and Coverage Limits

New SHBP members in the PPO or Indemnity options have a 12-month pre-existing condition (PEC) coverage limitation period. Each PEC is limited to \$1,000.

A PEC is any sickness, injury, or other condition for which medical advice, diagnosis, care, or treatment, including prescription medication, was recommended or received within six months immediately preceding a member's coverage effective date under the Plan.

SHBP members may reduce or eliminate the 12-month PEC limitation period by documenting "creditable coverage." Creditable coverage generally includes health coverage you or your family member had immediately before enrolling in the SHBP. Coverage under most group health insurance plans, individual health policies, and some governmental health programs qualify as creditable coverage. See the SPD for more details.

COBRA Rights

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that the Plan offer you, your spouse, or an eligible dependent, the opportunity to continue health coverage if Plan coverage is lost due to a qualifying event. The length of time you, or one of your dependents, may continue the coverage is based on the qualifying event. For further information, please refer to your SPD.

When Are Changes Allowed?

The benefit choices you make as a new hire will stay in effect for the duration of the 2006 Plan year – January 1, 2006 through December 31, 2006, unless you experience certain changes in status as defined by federal law. Section 125 of the Internal Revenue Code, which governs the SHBP, does not permit canceling or otherwise changing your coverage during the Plan year unless you have a qualifying event.

Qualifying events include, but are not limited to:

- Marriage or divorce;
- Birth or adoption of a child or placement for adoption;
- Death of a spouse or child, if only dependent enrolled;
- Your spouse's or dependent's eligibility for or loss of eligibility for other group health coverage;
- A change in residence by you, your spouse or dependents that makes you or a covered dependent ineligible for coverage in your selected option; and
- A change in employment status that leads to a loss or gain of eligibility under the Plan.

If you declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in the Plan, provided that you request enrollment within 31 days of when your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption, and provide the required documentation.

How to Remove Surcharges

Tobacco Surcharge

- You must attend a tobacco cessation program sponsored by Kaiser or the American Cancer Society. Additional programs may be approved in the future. Please check the DCH Web site for any updates at www.dch.georgia.gov.
- You will receive an attendance certification form. You and the representative should both sign this form.
- You should complete the appropriate Tobacco Affidavit Form available from SHBP at www.dch.georgia.gov.
- Give both forms to your employer's Benefit Coordinator to complete the required deduction information.

The change in premiums will be effective based on the payroll schedule of your employer. No refund in premium will be made for previous health deductions that included the surcharge amounts. IRS rules do not allow premium changes to be made retroactively.



For additional information about qualifying events, see your SPD available from you personnel office or online at: www.dch.georgia.gov.



Keep in mind that once you enroll or decline, you cannot change your coverage until the next Open Enrollment Period unless you experience a qualifying event that would permit a corresponding change.



SPOUSAL SURCHARGE
If your spouse becomes covered by his/her employer's health benefit plan, the surcharge can be removed if you make the request and provide proof within 31 days of the effective date of the other coverage.

State Health Benefit Plan Medicare Policy

Federal Law requires SHBP to pay primary benefits for active employees and their dependents as long as active employment continues. Active members or their covered dependents may choose to delay Medicare enrollment. Termination of active employment is a qualifying event for enrolling in Medicare without penalty.

You must enroll for coverage for you and any eligible dependents during the Open Enrollment period prior to your retirement if you want to have health insurance under SHBP when you retire, (if you are not already enrolled). Members who are enrolled in Medicare due to End Stage Renal Disease (ESRD) will need to contact the Social Security Administration to determine when Medicare becomes primary.

Once retired, during the annual Retiree Option Change Period, you are allowed to change your Plan option only. You may add dependents only if you experience a qualifying event, request the change within 31 days and provide documentation required by SHBP.

EMPLOYEE RESPONSIBILITIES

! If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, starting in 2006. Please see pages 24–28 for more details.

This booklet contains a brief explanation of each Plan Option, for January 1 – December 31, 2006 and a benefits comparison chart.

- Read the current Decision Guide and SPD to understand your Health Plan Options prior to making your health election.
- Contact your employer or payroll location Benefit Coordinator for assistance if you have benefit questions or, you may go to www.dch.georgia.gov and click on “How Do I” and then click on “Find Health Benefit Information as a New Hire or Transfer”.
- You will automatically be charged the surcharge(s) if you fail to answer all questions concerning the surcharges. The surcharge(s) will apply for the 2006 plan year unless you experience a qualifying event.
- Eligibility verification documents for all dependents for whom coverage has been requested should be submitted within the required time frame.
- A new SHBP member should provide a Certificate of Creditable Coverage from prior health insurance to reduce or eliminate any pre-existing condition limitation for the PPO or Indemnity Options.

Notify the Plan of any fraudulent activity regarding Plan members, providers, payment of benefits, etc. Call 1-877-878-3360, or 404-206-9514.

UNDERSTANDING YOUR PLAN OPTIONS

On the following pages, you will find a brief description of each option and important considerations to help you select the best option for you. To help you understand the information in this section, a few key terms are defined below.



Contact the Member Services unit for each option if you need more detail. Telephone numbers are on the inside front cover. You also may access an SPD online at: www.dch.georgia.gov.

Important Terms to Understand

Allowed Amount – A dollar amount the Plan uses to calculate benefits payable.

Balance Billing – A dollar amount charged by the provider that is over the Plan's allowed amount for the care received. You are subject to balance billing when you receive services from non-participating providers, including emergency services.

Co-insurance Amount – The percentage of the Plan's allowed amount paid by a Plan member. The SHBP generally pays 90% to 60% of the Plan's allowed amount for covered services, so your co-insurance is between 10% and 40%.

Co-payment – A set dollar amount that you pay at the time you receive services or items. For example, you pay a \$30 co-payment for an in-network PPO physician's office visit while you are at the physician's office. Co-payments do not apply to Plan year deductibles or out-of-pocket limits unless otherwise noted.

Covered Services – Services for medically necessary care that are eligible for reimbursement under the plan.

Deductible – A specified dollar amount, which varies by Plan option, for specified covered services that you must pay out-of-pocket each Plan year before the option pays a benefit. Depending on your coverage option, the deductible may not apply to some services. For example, the deductible does not apply to in-network physician office visits under the PPO Option.

Emergency Care – Care provided when a sudden, severe and unexpected illness or injury happens that could be life threatening or result in permanent impairment of bodily functions if not treated immediately.

Lifetime Maximum – The dollar amount that each Plan member may receive in benefits from the SHBP during his or her lifetime.

Out-of-Pocket Limits – The maximum amount you would have to pay out of your pocket each Plan year for covered services. Once you meet your out-of-pocket limit for the Plan year, the Plan pays 100% of the allowed amounts for most covered services for the rest of the Plan year. Your out-of-pocket costs for premiums, co-payments and non-covered charges are **not** applied to the limit. The deductible is applied to your annual out-of-pocket limit.

Participating Provider – Any physician, hospital or other health-service professional or facility that offers covered services and that has joined the PPO network, the Indemnity network, the High Deductible Health Plan network or HMO network for the Plan option. Providers nominated and accepted under a CCO are also considered participating providers for the person making the nomination. Participating providers may not balance bill Plan members for covered services.

To maximize your health benefits, it is important to fully understand how each of the SHBP options works. This brief overview will help you determine which option best fits your health care needs. **Keep in mind that failure to use network providers could result in a financial impact to you.**

PPO Options

The PPO Options offer you a network of more than 12,500 Georgia participating physicians and 150 Georgia hospitals.

You also have the added benefit of access to a national network of participating providers and hospitals across the United States.

In order to receive the highest level of benefit coverage and avoid filing claims and balance billing, you will need to use an in-network provider. If you choose to use an out-of-network provider, the reimbursement will be at a lower level of benefit coverage.

A PPO CCO is also available. See page 12 for more details.

To view the list of PPO providers, visit www.myuhc.com/groups/gdch, or call 1-877-246-4189.

HMO Options

HMO Options are available to SHBP eligible employees if the HMO is offered in your area or surrounding counties.

HMOs provide 100% benefit coverage for preventive health care needs after paying applicable co-payments. There are no bills or claim forms. Certain services are subject to a deductible and co-insurance amount (i.e., inpatient and outpatient hospital facility, inpatient professional charges, etc.). These deductibles and co-insurance amounts have an annual out-of-pocket maximum. When you meet this maximum, the HMO pays your covered services at 100%. **Co-payment amounts are excluded from the annual out-of-pocket maximum.**

In HMOs, you are responsible for selecting a Primary Care Physician (PCP) from a list of participating providers (see note). You must be referred to a network provider by your participating physician or facility for your expenses to be covered, except in emergencies and in other limited cases. If you receive care from a provider other than your PCP, or without your PCP's referral, there is no coverage even if the physician or facility is in the HMO network.

An HMO CCO is also available. See page 12 for more details.



It is ultimately your responsibility to verify that a provider is in the PPO, HDHP or HMO network prior to receiving services. Providers may enter or leave the network at any time.



NOTE: UnitedHealthcare HMO does not require you to select a PCP or obtain referrals to see specialists.



Diagnostic testing and lab services performed at independent radiology and lab offices located in the Kaiser facilities are subject to deductible and co-insurance.

High Deductible Health Plan

A High Deductible Health Plan (HDHP) will be offered to all employees effective January 1, 2006. This Option offers you a new way to manage your healthcare dollars. When you enroll:

- Your monthly insurance premiums are lower.
- You may qualify to start a Health Savings Account (HSA) for yourself, through a bank or other financial organization acting as an HSA custodian/administrator, and set aside tax-free dollars to pay for eligible healthcare expenses now or in the future. HSAs typically earn interest and may even offer investment options.

You may start an HSA when you enroll in the HDHP as long as you do not have other medical coverage. You will be responsible for selecting your HSA vendor, setting up your account, and making contributions.

In return for the lower premiums and the potential tax advantages of a Health Savings Account, you take on more responsibility for your healthcare needs when you enroll in the HDHP. You:

- Have a higher deductible, with benefits payable only after you meet the deductible (except for preventive care coverage)
- Pay coinsurance after you have satisfied the deductible rather than set dollar co-payments for network office visits and prescription drugs.
- Another tax savings option you may want to consider is a Health Care Spending Account (HCSA), if it is offered through your employer's cafeteria program. A HCSA helps you save tax dollars, approximately 26-45%, depending on your tax situation. By electing to use a HCSA, you may set aside up to \$5,040 annually to cover health-related treatment expenses for yourself and your dependents. If you contribute to a HCSA, it is your responsibility to make sure your contributions do not violate any HSA rules.



See page 22 for more details on the new HDHP and the opportunity it provides to enroll in a Health Savings Account.

See the Benefits Comparison that starts on page 14 for more about how the Plan covers specific expenses.

PPO, HMO and High Deductible Health Plan Consumer Choice Options (CCO)

Selection of any CCO option does not provide enhanced benefits.

The CCO premiums are higher than the corresponding Option. For the increased cost, you can request that a Georgia out-of network provider be reimbursed as an in-network provider. This is referred to as a nomination.

The out-of-network provider must accept the fees and conditions of the network and be approved by the network BEFORE you receive any services from that provider.

This in-network relationship between you and the provider exists only for you and the provider. Other family members who wish to receive in-network benefits from that provider must complete a provider nomination form. You may nominate as many providers as you wish.

SHBP rules do not allow you to change your coverage option if the provider you would like to nominate rejects the nomination.

Only providers located and licensed in Georgia are eligible for nomination.



For further details and to obtain the necessary nomination paperwork,

please call the selected plan option member services department.

Indemnity Option

The Indemnity Option is a traditional fee-for-service plan that generally provides the same benefit coverage level no matter which qualified medical provider you use. The Plan reimburses up to the Plan's allowed amounts for covered services. The Indemnity Option also uses contracted healthcare providers who have agreed to discounted rates without balance billing for charges over the allowed amount. As long as you see a participating provider, you may not be balance billed for covered services. However, not all providers participate in these special arrangements. In most instances, non-participating providers' billed charges are considerably higher than the Plan's allowed amounts.

The SHBP does not have the legal authority to intervene when non-participating providers balance bill you. As a result, the SHBP cannot reduce or eliminate amounts balance billed. The SHBP cannot make additional payments above the allowed amounts when you are balance billed by non-participating providers.

TRICARE Supplement for Eligible Military Members

The TRICARE Supplemental Insurance is offered to employees and dependents who are eligible for TRICARE and who have a Defense Enrollment Eligibility Reporting System (DEERS) number.*

Considerations

- TRICARE will become your primary insurance.
- TRICARE Supplement will become your secondary coverage.
- TRICARE covers full-time students only to age 23. You must select another SHBP option during the Open Enrollment period prior to your child reaching age 23 to cover a full-time student from age 23 to 26. (Reaching age 23 as a full-time Student is not a qualifying event).
- Tobacco and spousal surcharges do not apply.
- COBRA legislation requires SHBP to offer continuation of coverage when coverage is lost. If you elect COBRA and the premiums are paid, there is NO break in SHBP coverage. If you elect coverage through the Association and Society Insurance Corporation's (ASI) portability feature instead of COBRA, you will no longer be covered by SHBP.

What Happens at Age 65

- When you and/or your spouse are ineligible for Medicare, TRICARE Supplement continues with submission of disallowance by Social Security.
- When you and/or your spouse are entitled to Medicare Part A and enrolled in Medicare Part B, your coverage will continue through TRICARE Supplement.
- When you and/or your spouse are eligible for Medicare, Medicare will be your primary insurance TRICARE for Life – secondary and TRICARE Supplement – Tertiary.
- When you or your spouse are eligible for Medicare, if you wish to cover your spouse through SHBP, you need to select another Option during the Open Enrollment Period prior to you or your spouse reaching age 65.
- Attainment of age 65 and eligibility for Medicare is a qualifying event and will allow you to change to another Plan option.
- When you and/or your spouse reach age 65 and reside overseas, your coverage will continue through the TRICARE Supplement if you are entitled to Medicare Part A and are enrolled in Medicare Part B.



***TRICARE covers dependents to age 23 even if they are not a full-time student. However, SHBP only covers dependents who are not full-time students to age 19. You should not elect the TRICARE Supplement if you wish to cover a child who is between the ages of 19 and 23 and is not a full-time student.**



If you enroll in TRICARE Supplement and are not eligible, you will be enrolled in the PPO Option which includes the spousal and tobacco surcharges. You will be required to pay the PPO premiums retroactive to your date of ineligibility or your coverage will be terminated effective January 1, 2006.

BENEFITS COMPARISON: PPO, INDEMNITY, HDHP AND HMO OPTIONS

Schedule of Benefits for You and Your Dependents for January 1, 2006– December 31, 2006

Dollar amounts, visit limitations, deductibles and out-of-pocket limits are based on a January 1–December 31, 2006 Plan Year.

NOTE: Coverage is defined as allowed eligible expenses.

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Covered Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
Maximum Lifetime Benefit (combined for all SHBP Options)	\$2 million		\$2 million
Pre-Existing Conditions (1st year in Plan only, subject to HIPAA)	\$1,000		\$1,000
Lifetime Benefit Limit for Treatment of: (combined for PPO Option, Indemnity and HDHP) • Temporomandibular joint dysfunction (TMJ) • Substance abuse	\$1,100 3 episodes		\$1,100 3 episodes
Deductibles • Deductible—individual • Deductible—family maximum	\$500 \$1,500	\$600 \$1,800	\$500 \$1,500
• Hospital deductible per admission	\$250		\$400
Annual Out-of-Pocket Limits: • Individual • Family	\$1,100 \$2,200	\$2,200 \$4,400	\$2,200 \$4,400
Physicians' Services			
Primary Care Physician or Specialist Office or Clinic Visits: Treatment of illness or injury	100% after a \$30 per visit co-payment; not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Primary Care Physician or Specialist Office or Clinic Visits for the Following: • Wellness care/preventive healthcare • Annual gynecological exams (these services are not subject to the deductible)	100% after \$30 co-payment per office visit. No co-payment for associated tests and immunizations. Maximum of \$500 per person per Plan Year.	Not covered. Charges do not apply to deductible or annual out-of-pocket limits.	90% per office visit after deductible. No deductible for associated lab and test charges, up to a maximum of \$200 per person per Plan Year; additional \$125 benefit for screening mammogram.
Maternity Care (prenatal, delivery and postpartum)	90% of coverage; not subject to deductible after initial \$30 co-payment	60% of coverage; subject to deductible	90% of coverage; subject to deductible

Exclusions and limitations vary among Plan options. Contact your specific Plan option for more information.

HIGH DEDUCTIBLE OPTION (HDHP)		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
\$2 million		\$2 million	
None		None	
\$1,100 3 episodes		No separate lifetime benefit limit	
\$1,100 \$2,200	\$2,200 \$4,400	\$200 \$400	
Not applicable		Not applicable	
\$1,700 \$2,900	\$3,800 \$7,000	\$1,000 \$2,000	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after a per visit co-payment** of \$20 for primary care and \$25 for specialty care	** Includes lab and x-rays done in the physician's office.
100% coverage up to a maximum of \$500 per person per plan year. Not subject to deductible.	Not covered, charges do not apply to deductible or annual out-of-pocket limits.	100% after a per visit co-payment of \$20 for primary care and \$25 for specialty care. No co-payment for immunizations and mammograms.	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after initial \$25 co-payment	

Chart continued pg. 16

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Physicians' Services	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
Physician Services Furnished in a Hospital Surgery in general, including charges by surgeon, anesthesiologist, pathologist and radiologist	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Physician Services for Emergency Care	90% of coverage; subject to deductible	90% of coverage; subject to in-network deductible	90% of coverage; subject to deductible
Outpatient Surgery— • When billed as office visit	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
• When billed as outpatient surgery at a facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Allergy Shots and Serum	100% for shots and serum after \$30 per visit co-payment not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Hospital Services			
Inpatient Services • Inpatient care, delivery and inpatient short-term acute rehabilitation services	90% of coverage; subject to a \$250 per admission deductible	60% of coverage; subject to a \$250 per admission deductible	90% of coverage; subject to a \$400 per admission deductible
• Well-newborn care	100% of coverage; not subject to deductible	Not covered	90% of coverage; not subject to deductible
Covered Services			
Outpatient Surgery—Hospital/Facility	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Emergency Care Treatment of an emergency medical condition or injury	90% of coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to deductible	90% of coverage after a \$100 per visit co-payment; co-payment waived if admitted; subject to deductible
Outpatient Testing, Lab, etc.			
Laboratory; X-Rays; Diagnostic Tests; Injections, including Medications Covered Under Medical Benefits—for the Treatment of an Illness or Injury	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after \$100 co-payment	Non-emergency use of the emergency room not covered.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after \$25 co-payment if billed as office visit	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% for shots and serum after a \$25 per visit co- payment	Kaiser Permanente – \$5 for shots and \$50 for a three-month supply of serum
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage not subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after a \$100 per visit co-payment; co-payment waived if admitted	Non-emergency use of the emergency room not covered.
90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible	

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Behavioral Health	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
Mental Health and Substance Abuse Inpatient Facility NOTE: All services require prior authorization.	90% of coverage; subject to deductible limited to 45 days combined per Plan Year	60% of coverage; subject to deductible limited to 45 days combined per Plan Year	90% of coverage; subject to deductible limited to 45 days combined per Plan Year
Partial Day Hospitalization and Intensive Outpatient NOTE: Notification Required.	90% of coverage; subject to deductible limited to 60 days combined per Plan Year	No benefit	90% of coverage; subject to deductible limited to 60 days combined per Plan Year
Professional Charges Inpatient	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year	90% of coverage; subject to deductible; limited to 1 visit per authorized day combined per Plan Year
Mental Health and Substance Abuse Outpatient Visits NOTE: Notification Required.	90% of coverage; subject to deductible, limited to 50 visits combined per Plan Year	60% of coverage; subject to deductible; limited to 25 visits combined per Plan Year	90% of coverage; subject to deductible; limited to 50 visits combined per Plan Year
Dental			
Dental and Oral Care NOTE: Coverage for most procedures for the prompt repair of sound natural teeth or tissue for the correction of damage caused by traumatic injury.	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Temporomandibular Joint Syndrome (TMJ) NOTE: Coverage for diagnostic testing and non-surgical treatment up to \$1,100 per person lifetime maximum benefit. This does not apply to the HMO	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Vision			
	90% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	90% of coverage; not subject to deductible; limited to one eye exam every 24 months
Other Coverage			
Ambulance Services for Emergency Care NOTE: "Land or air ambulance" to nearest facility to treat the condition.	90% of coverage; subject to deductible	90% of coverage; subject to deductible	90% of coverage; subject to deductible

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
90% of coverage; subject to deductible limited to 30 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	90% of coverage; not subject to deductible and limited to 30 days combined per Plan Year	Kaiser Permanente – 90% of coverage; subject to deductible and unlimited days for mental health; 30-day limit for substance abuse
90% of coverage; subject to deductible limited to 60 days combined per Plan Year	60% of coverage; subject to deductible limited to 30 days combined per Plan Year	Each HMO may or may not offer this benefit; contact the HMO for more information	
90% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	60% of coverage; subject to deductible limited to 1 visit per authorized day combined per Plan Year	90% of coverage; not subject to deductible	Kaiser Permanente – 90% of coverage; subject to deductible
90% of coverage; subject to deductible limited to 50 visits combined per Plan Year	60% of coverage; subject to deductible limited to 25 visits combined per Plan Year	100% after \$25 per visit co-payment; limited to 25 visits combined per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after applicable co-payment, if inpatient/outpatient facility; subject to deductible	Kaiser Permanente – 50% coverage on first \$1,000, if inpatient/outpatient facility; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after applicable co-payment for related surgery and diagnostic services; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible	Kaiser Permanente – 50% for non-surgical treatment; excludes appliances and orthodontic treatment; if inpatient/outpatient facility, 90% subject to deductible
90% of coverage; not subject to deductible; limited to one eye exam every 24 months	Eye exam not covered	Contact HMO directly for more information	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100%	Kaiser Permanente – 100% after a \$50 per trip co-payment when medically necessary.

Chart continued pg. 20

	PPO OPTION		INDEMNITY
	In-Network	Out-of-Network	
Other Coverage	<i>The Plan Pays:</i>		<i>The Plan Pays:</i>
Urgent Care Services	90% of coverage after a \$45 per visit co-payment; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Home Healthcare Services NOTE: Prior approval required	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Skilled Nursing Facility Services NOTE: Prior approval required	90% of coverage; up to 45 days per Plan Year; subject to a \$250 per admission deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to a \$400 per admission deductible @ contracted facility
Hospice Care NOTE: Prior approval required	100% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible
Durable Medical Equipment (DME)—Rental or Purchase	90% of coverage; subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Outpatient Acute Short-Term Rehabilitation Services	90% of coverage; subject to deductible and \$20 per visit co-payment up to 40 visits per Plan Year	60% of coverage; subject to deductible and \$20 per visit co-payment up to 40 visits per Plan Year	90% of coverage; subject to deductible and \$20 per visit co-payment up to 40 visits per Plan Year
Chiropractic Care NOTE: Coverage for up to a maximum of 20 visits per Plan Year	90% of coverage; after a \$30 per visit co-payment; not subject to deductible	60% of coverage; subject to deductible	90% of coverage; subject to deductible
Transplant Services NOTE: Prior approval required	90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible at contracted transplant facility
Pharmacy			
Generic Co-payment	\$10	\$10	\$10
Preferred Brand Co-payment	\$30	\$30	\$30
Non-Preferred Brand Co-payment	\$100	\$100	\$100

HIGH DEDUCTIBLE OPTION		HMO OPTIONS	
In-Network	Out-of-Network	BlueChoice, CIGNA, Kaiser Permanente, UnitedHealthcare	
<i>The Plan Pays:</i>		<i>The Plan Pays:</i>	<i>HMO Plan Differences</i>
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% after \$25 co-payment	BlueChoice – referral required. Kaiser Permanente – 100% after \$30 co-payment
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; up to 120 visits per Plan Year	
90% of coverage up to 45 days per Plan Year; subject to deductible	Not covered	90% of coverage; up to 45 days per Plan Year; subject to deductible	United Healthcare – 90% of coverage, up to 120 days per Plan Year; subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage; subject to deductible	CIGNA – 90% of coverage; subject to deductible; outpatient 100% not subject to deductible
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage when medically necessary	
90% of coverage up to 40 visits per Plan Year; subject to deductible	60% of coverage up to 40 visits per Plan Year; subject to deductible	100% of coverage after \$25 per visit co-payment; up to 40 visits per Plan Year	
90% of coverage; subject to deductible	60% of coverage; subject to deductible	100% of coverage after \$25 co-payment per visit	
90% of coverage; subject to deductible at contracted transplant facility	Not covered	90% of coverage; subject to deductible	
80% of coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$10	Kaiser Permanente – Kaiser facility: \$10 Eckerd Drugs: \$16
80% of coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$25	Kaiser Permanente – Kaiser facility \$25 Eckerd Drugs: \$31
80% of coverage; subject to deductible \$10 min./\$100 max.	Not covered	\$50	Kaiser Permanente – N/A

IMPORTANT PLAN CONSIDERATIONS



If you are covered under the PPO, Indemnity, High Deductible Health Plan or CCO option, for these options, you are required to obtain the necessary prior notification or prior approval for all inpatient admissions and certain covered services under the Plan. You should contact member services regarding notification requirements and verification of covered services.

PPO and Indemnity Progressive Drug Management Program (PDMP)

This program assists your doctor in finding the most appropriate drug for you. The first step is usually a proven, less expensive treatment known to be safe and effective. If the drug does not work for you, your doctor may progress to another drug. A prior authorization may be required as the next step in the program.

Note: If you should go to the pharmacy and are told that your prescription cannot be filled because it requires prior authorization, please have your doctor call Express Scripts with your clinical information.

Important PPO, Indemnity Considerations

See the Summary Plan Description for coverage details, including limitations and exclusions.

- Some services may require prior approval before such services are covered. **Prior notification is the member's responsibility to obtain.** Also, some services may have limitations not contained in this summary.
- Charges from non-participating providers are subject to balance billing. These charges are the member's responsibility and do not count toward deductibles or out-of-pocket spending limits.
- Services covered under the PPO from in-network providers will apply to the in-network deductible and out-of-pocket limit.
- Services covered under the PPO from out-of-network providers apply to the out-of-network deductible and out-of-pocket limit.
- Co-payments do not apply toward deductibles or out-of-pocket limits unless otherwise noted.

High Deductible Health Plan Considerations

The HDHP covers the same services and supplies as the SHBP's PPO Option, and includes the same network of participating physicians and hospitals – here in Georgia and across the United States. The HDHP also reflects the importance of preventive care, with a \$500 annual benefit with no deductible.

Deductibles:

- The deductible applies to everything except the first \$500 in preventive care expenses. If you have family coverage, you must meet the family deductible before benefits are payable for any family member.
- With the HDHP, you pay coinsurance after the deductible for in-network office visits and prescription drugs.

Your Health Savings Account (HSA) Opportunity

An HSA is like a personal savings account for healthcare, except it's all tax-free. When you enroll in the HDHP, you may be eligible to open a HSA with an independent HSA administrator/custodian. You will need to contact a local bank or other financial organization to set-up your HSA Account.

You may open a HSA if you enroll in the HDHP and do not have other coverage – through your spouse's employer's plan, Medicare, Medicaid, a full unrestricted HCSA – or any other medical plan.

HSA Highlights

What you can contribute each year	Up to HDHP deductible amount: <ul style="list-style-type: none">• \$1,100 if you have individual coverage• \$2,200 if you have family coverage as long as you continue to be enrolled in the HDHP. If you are 55 or older, you may contribute additional dollars – up to \$700/year – as “catch-up” contributions
How you contribute	Through deposits you make directly to the HSA administrator you select...either in a lump sum or in installments throughout the year. Payroll deductions may be available through your employer.

HSA Highlights *continued*

What you can use your HSA to pay	Healthcare expenses (medical, dental, vision, over-the-counter medications) the IRS considers tax-deductible that aren't covered by any healthcare plan...see IRS Publication 502 at www.irs.gov .
How claims are paid	Varies based on HSA administrator, but generally you can pay expenses directly from your account (using a debit card or convenience checks), so there's no claim paperwork to submit
What happens at the end of the year	Unused money in your account carries forward and continues to earn interest
What happens if you don't enroll in the HDHP next year or leave your employer	You can no longer contribute to your HSA, but you keep the account and can continue to use the balance for eligible healthcare expenses

Points to Consider when selecting your HSA Administrator/Custodian

- **The organization's credentials:** As you look at an insurance company, a bank or other HSA custodian, check out its reputation for service, quality, licensing and financial stability.
- **Investment options:** How much interest will your HSA earn? Money market accounts typically earn 0.5% to 3.0% interest. Will you have a choice of investment options? Some HSA administrators require that your account balance reaches a certain threshold before you have investment choices.
- **Claim payment:** Many administrators offer a debit card that can be used at the doctor's office or pharmacy to pay your share of the cost of care, or even at an ATM to reimburse yourself for qualified expenses you have paid. Most offer checks, sometimes for an extra fee.
- **Account fees:** HSA administrators (typically) charge a set-up fee and a monthly maintenance fee. Sometimes there are additional transaction fees.

Important HMO Considerations

- Some services may require prior authorization by the HMO before such services are covered. Also, some services may have limitations not contained in this summary.
- Most HMOs require the selection of a primary care physician (PCP) to manage your care. Failure to specify a PCP could delay receipt of your ID card. However, in some instances the HMO assigns you a PCP located near your residence if a PCP is not specified. **Note: UnitedHealthcare does not require the selection of a PCP.**
- Most HMOs require you to obtain referrals to see most specialists. Failure to obtain a referral could result in denial of your claim. **Note: UnitedHealthcare does not require a referral for coverage of specialist services.**



NOTES APPLY TO ALL OPTIONS:

- Preferred Drug Lists for SHBP members are subject to change. Prior to purchasing your medication(s), PPO and Indemnity members may view the drug lists at www.dch.georgia.gov or contact Express Scripts at 1-877-650-9342 or TDD 1-800-842-5754. HMO members may contact the HMO plan in which they are enrolled.
- Many drugs listed as non-preferred have a generic or a preferred brand name alternative. Preferred drug alternatives are therapeutically equivalent while being more cost effective.
- If the drug cost is less than the co-payment, you do not have to pay the co-payment but the actual cost of the drug.
- Co-payments for drugs covered under the SHBP will not be changed or overridden on an individual basis.
- The SHBP defines maintenance drugs as medications for specified chronic conditions. PPO, PPO CCO, Indemnity and Kaiser members may obtain up to a 90-day supply of maintenance prescription(s) at one time for three co-payments. BlueChoice, CIGNA, and UnitedHealthcare members may receive a 90-day supply of maintenance prescriptions for two co-payments. Your co-payments are based on supplies of up to 30 days as this is the industry standard. However, some drugs are limited to a standard other than the 30-day supply for one co-payment.
- Lifetime benefit maximums are combined totals among the PPO Options, Indemnity, HDHP Option and HMO Options.
- Annual dollar and visit limitations, deductibles and out-of-pocket spending limits are based on January 1, 2006 to December 31, 2006.
- Contact each plan directly for more details regarding covered services, exclusions and limitations.

IF YOU ARE RETIRING...WHAT YOU NEED TO KNOW



If you want to have health insurance under SHBP when you retire, you must enroll for coverage for you and any eligible dependents during the Open Enrollment period prior to your retirement.

Once retired, during the annual Retiree Option Change Period, you are allowed to change your Plan option only. You may add dependents only if you experience a qualifying event and request the change within 31 days.

The following information and “Important Notices about your Prescription Drug Coverage and Medicare” are provided to assist you with Retirement Planning.

- 1 SHBP will pay primary benefits for non-enrolled Medicare eligible retirees as well as retirees who are not entitled to Medicare because they did not participate in Social Security or pay Medicare taxes. The premiums for these primary payments will be increased the month in which the retiree (or dependent spouse) becomes 65 or becomes eligible for Medicare due to disability.
- 2 Effective January 1, 2006, the SHBP will implement a new Medicare policy. SHBP will calculate premiums and claims payment based upon Medicare enrollment for retirees over age 65 or those eligible for Medicare due to disability. As in the past, SHBP will coordinate benefits for members who are enrolled for Medicare Part A and/or B. Additionally, coordination will also begin for retirees who enroll in the Medicare Part D Prescription Drug Plan (PDP). Premiums will be reduced for each part of Medicare for which the retiree enrolls.

Additional Information Concerning Medicare Part D

Medicare Part D will offer a standard and enhanced prescription drug plan if you are eligible for Part A and/or enrolled in Part B, you are eligible for Part D. If you are considering enrolling in a Part D plan, SHBP suggests that you enroll in a standard plan. The standard plan and the coordination of benefits with SHBP should meet your coverage needs. Please note that certain medications have specific Quantity Level Limits and some require Prior Authorization. The SHBP will still apply these requirements and limits to your prescription drug coverage.

If you will be retiring and are considering enrolling in the Kaiser Medicare Advantage (MA) option, you must make your election on the Membership Worksheet and submit to SHBP. Kaiser will mail you a Senior Advantage application that you will need to complete. You should also check Medicare Part D on this application. By checking this box, you are agreeing to have Part D Prescription Drug Coverage administered by Kaiser.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

PPO, Indemnity, CIGNA, United Healthcare HMO, Kaiser Permanente, BlueChoice and TRICARE Supplement Plan Options

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and the new prescription drug coverage available soon for people with Medicare.

- 1 Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
- 2 DCH has determined that the prescription drug coverage offered by the SHBP is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
- 3 Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

People with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. Each year after that, you will have the opportunity to enroll in a Medicare prescription drug plan between November 15 through December 31.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.



Because your existing coverage with one of the following SHBP

Options: PPO, Indemnity, CIGNA, United Healthcare HMO, Kaiser Permanente, BlueChoice, and TRICARE Supplement is on average at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.



If you do decide to enroll in a Medicare prescription drug plan and drop your coverage with the SHBP, be aware that your next opportunity to enroll with the SHBP will be during the 2006 Open Enrollment for calendar year, January 1, 2007 through December 31, 2007, or if there is a qualifying event.



REMEMBER TO KEEP THIS NOTICE. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

You should also know that if you drop or lose your coverage with SHBP and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1 percent per month for every month after May 15, 2006, that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage...contact your Pharmacy Benefit Manager at the number on your identification card or call the State Health Benefit Plan at 404-651-6142 or 800-610-1863. NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

More information about your options under Medicare prescription drug coverage...will be available in October 2005 in the "Medicare & You 2006" handbook. You'll get a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number).
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Please contact the Social Security Administration (SSA) at 1-800-772-1213 (TTY 1-800-325-0778) or visit their Web site at www.socialsecurity.gov for more information about this extra help.

IMPORTANT NOTICE ABOUT YOUR HDHP PRESCRIPTION DRUG COVERAGE AND MEDICARE

High Deductible Health Plan Option

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the State Health Benefit Plan (SHBP) and new prescription drug coverage available soon for people with Medicare.

- 1 Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare.
- 2 DCH has determined that the prescription drug coverage under the High Deductible Health Plan Option offered by the SHBP is, on average for all plan participants, NOT expected to pay as much as the standard Medicare prescription drug coverage will pay. This is important, because for most people, enrolling in Medicare prescription drug coverage before May 15, 2006, means you will get more assistance with drug costs.
- 3 You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll. Read this information carefully – it explains your options.

Starting January 1, 2006, prescription drug coverage will be available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug coverage will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because the coverage you have with the State Health Benefit Plan is on average for all plan participants in the High Deductible Health Plan Option, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay, you might want to consider enrolling in a Medicare prescription drug plan. You can first join between November 15, 2005 and May 15, 2006. This is important, because if you do not get Medicare prescription drug coverage (or equivalent coverage) before May 15, 2006, you may have to pay a higher premium if you join later. You will pay that higher premium as long as you have Medicare prescription drug coverage.

If you don't enroll in Medicare prescription drug coverage by May 15, 2006, you may pay more. If you enroll after May 15, 2006, your monthly premium for a Medicare prescription drug plan could be much higher. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your premium will go up at least 1 percent per month for every month after May 15, 2006, that you did not have that coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19 percent higher than what most other people pay.

If you don't enroll in a Medicare prescription drug plan by May 15, 2006, you may also have to wait to enroll. Generally, after May 15, 2006, you can only join a Medicare prescription drug plan between November 15 and December 31 of any year. This may mean the number of months you have to wait for coverage will be longer, which could make your premium higher.

In addition, your current coverage pays for other health expenses, in addition to prescription drugs. You will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You need to make a decision. When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

For more information about this information or your current prescription drug coverage...contact your Pharmacy Benefit Manager at the number on your identification card or call the State Health Benefit Plan at 404-651-6142 or 1-800-610-1863.

NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...more detailed information about Medicare plans that offer prescription drug coverage will be available in October 2005 in the "Medicare & You 2006" handbook from Medicare you will receive in the mail. You may also be contacted directly by Medicare-approved prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number).
- Call 1-800 MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) ANNUAL NOTICE

This section describes certain rights available to you under the Health Insurance Portability and Accountability Act (HIPAA) when you enroll in the SHBP.

The PPO, PPO CCO and Indemnity Options contain a pre-existing condition (PEC) limitation. Specifically, the Health Plan will not pay charges that are over \$1,000 for the treatment of any pre-existing condition during the first 12 months of a patient's coverage, unless the patient gives satisfactory documentation that he or she has been free of treatment or medication for that condition for at least six consecutive calendar months. If you are enrolling as a new hire, this 12-month period begins on your hire date. However, a pre-existing condition limitation does not apply to coverage for:

- Pregnancy; or
- Newborns or children under age 18 who are adopted or placed for adoption, if the child becomes covered within 31 days after birth, adoption or placement for adoption.

In certain situations, SHBP members and dependents can reduce the 12-month pre-existing condition limitation period. The reduction is possible by using what is called "creditable coverage" to offset a pre-existing condition period. Creditable coverage generally includes the health coverage you or a family member had immediately prior to joining the SHBP. Coverage under most group health plans, as well as coverage under individual health policies and governmental health programs, qualifies as creditable coverage.

To reduce the pre-existing condition limitation period for your own coverage, you must provide the SHBP with a certificate of creditable coverage from one or more former health plans or insurers that states when your prior coverage started and ended. Any period of prior coverage will reduce the 12-month limitation period if the time between losing coverage and your first day of SHBP coverage does not exceed 63 days. If you are enrolling as a new hire, the 63-day period is measured from your last day of prior coverage up to your date of hire.

To reduce the pre-existing condition limitation period for your dependents (including your spouse), you must provide the SHBP with a certificate of creditable coverage stating when coverage started and ended for each dependent that you want to cover. Again, any period of prior coverage for that dependent will reduce the 12-month limitation period if no more than 63 days have elapsed between the dependent's loss of prior coverage and the first day of coverage under the SHBP (or your date of hire, if you are enrolling as a new hire).

Within two years after your former coverage terminated, you have the right to obtain a certificate of creditable coverage from your former employer(s) to offset the pre-existing condition limitation period under the SHBP. The SHBP will evaluate your certificate of creditable coverage or other documentation to determine whether any of the pre-existing condition limitation period will be reduced or eliminated. After completing the evaluation, the SHBP will notify you as to how the pre-existing condition limitation period will be reduced or eliminated.



If you or a dependent (including a spouse) had any break in coverage lasting more than 63 days, you or your dependent will receive creditable coverage only for the period of time after the break ended.



Please submit your certificate of creditable coverage to the Plan with your enrollment paperwork. If you require assistance in obtaining a letter from a former employer, contact your personnel/payroll office.

DEPARTMENT OF COMMUNITY HEALTH

PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Plan's Privacy Commitment to You

The Georgia Department of Community Health (DCH) understands that information about you and your family is personal. DCH is committed to protecting your information. This notice tells you how DCH uses and discloses information about you. It tells you your rights and the Plan's requirements about your information.

Understanding the Type of Information That the Plan Has

Your employer (state agency, school system, authority, etc.) sent information about you to DCH. This information included your name, address, birth date, phone number, Social Security Number and other health insurance policies that you may have. It may also have included health information. When your health care providers send claims to the Plan's claim administrator for payment, the claims include your diagnoses and the medical treatments you received. For some medical treatments, your healthcare providers send additional medical information to the Plan such as doctor's statements, x-rays or lab test results.

Your Health Information Rights

You have the following rights regarding the health information that DCH has about you:

- You have the right to see and obtain a copy of your health information. An exception is psychotherapy notes. Another exception is information that is needed for a legal action relating to DCH.
- You have the right to ask DCH to change health information that is incorrect or incomplete. DCH may deny your request under certain circumstances.
- You have the right to request a list of the disclosures that DCH has made of your health information beginning in April 2003.
- You have the right to request a restriction on certain uses or disclosures of your health information. DCH is not required to agree with your request.
- You have the right to request that DCH communicates with you about your health in a way or at a location that will help you keep your information confidential.
- You have the right to receive a paper copy of this notice. You may ask DCH staff to give you another copy of this notice, or you may obtain a copy from DCH's Web site, www.dch.georgia.gov (click on "Privacy").

Privacy Law's Requirements

DCH is required by law to:

- Maintain the privacy of your information.
- Give you this notice of DCH's legal duties and privacy practices regarding the information that DCH has about you.
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may take away your permission at any time, in writing, except for the information that DCH disclosed before you stopped your permission. If you cannot give your permission due to an emergency, DCH may release the information if it is in your best interest. DCH must notify you as soon as possible after releasing the information.

In the future, DCH may change its privacy practices. If its privacy practices change significantly, DCH will provide a new notice to you. DCH will post the new notice on its Web site at www.dch.georgia.gov (click on "Privacy"). This notice is effective April 14, 2003.

How DCH Uses and Discloses Healthcare Information

There are some services the Plan provides through contracts with private companies. For example, UnitedHealthcare of Georgia pays most medical claims to your healthcare providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

For Payment

The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your healthcare provider sends a claim for payment to the claims administrator. The claim includes information that identifies you, as well as your diagnoses and treatments.

For Medical Treatment

The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, if you participate in a Disease State Management Program, the Plan may send you information about your condition.



Under the HIPAA Privacy Law, you may authorize the Plan to release your Personal Health Information (PHI) to another individual. If you have authorized the release of PHI to another individual, the personal representative form authorizing the release of your PHI is not transferred between options. This is for the protection of your privacy. If you wish to continue to designate another individual after changing health options, you may be asked to complete a new personal representative form.

To Operate Various Plan Programs

The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews hospital records to check on the quality of care that you received and the outcome of your care.

To Other Government Agencies Providing Benefits or Services

The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services and will be authorized by you or by law.

To Keep You Informed

The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about prescription drugs you are taking.

For Overseeing Healthcare Providers

The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as hospitals, as required by law.

For Research

The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.

As Required by Law

The Plan will disclose information about you as required by law.

For More Information and to Report a Problem

If you have questions and would like additional information, you may contact the SHBP at 404-656-6322 (Atlanta calling area) or 1-800-610-1863 (outside of Atlanta calling area).

If you believe your privacy rights have been violated:

- You can file a complaint with the Plan by calling the SHBP at 404-656-6322 (Atlanta calling area) or 1-800-610-1863 (outside of Atlanta calling area), or by writing to: SHBP-HPU, P.O. Box 38342, Atlanta, GA 30334.
- You can file a complaint with the Health and Human Services Office for Civil Rights by writing to: U.S. Department of Health and Human Services Office for Civil Rights, Region IV, Atlanta Federal Center, 61 Forsyth Street SW, Suite 3B70, Atlanta, GA 30303-8909. Phone 404-562-7886; Fax 404-562-7881; TDD 404-562-7884.
- You also may contact the HHS Office for Civil Rights by calling 1-866-OCR-PRIV 1-866-627-7748 or e-mail to OCRComplaint@hhs.gov.

There will be no retaliation for filing a complaint.

Women's Health and Cancer Rights Act

The Plan complies with the Women's Health and Cancer Rights Act of 1998. Mastectomy, including reconstructive surgery, is covered the same as other surgery under your Plan option.

Following cancer surgery, the SHBP covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Reconstruction of the other breast to achieve a symmetrical appearance.
- Prostheses and mastectomy bras.
- Treatment of physical complications of mastectomy, including lymphedema.

For more detailed information on the mastectomy-related benefits available under the Plan, you can contact the Member Services unit for your coverage option. Telephone numbers are on the inside front cover.

Penalties for Misrepresentation

If an SHBP participant misrepresents eligibility information when applying for coverage, during change of coverage or when filing for benefits, the SHBP may take adverse action against the participant, including but not limited to terminating coverage (for the participant and his or her dependent[s]) or imposing liability to the SHBP for fraud or indemnification (requiring payment for benefits to which the participant or his or her beneficiaries were not entitled). Penalties may include a lawsuit, which may result in payment of charges to the Plan or criminal prosecution in a court of law.

In order to avoid enforcement of the penalties, the participant must notify the SHBP immediately if a dependent is no longer eligible for coverage or if the participant has questions or reservations about the eligibility of a dependent. This policy may be enforced to the fullest extent of the law.



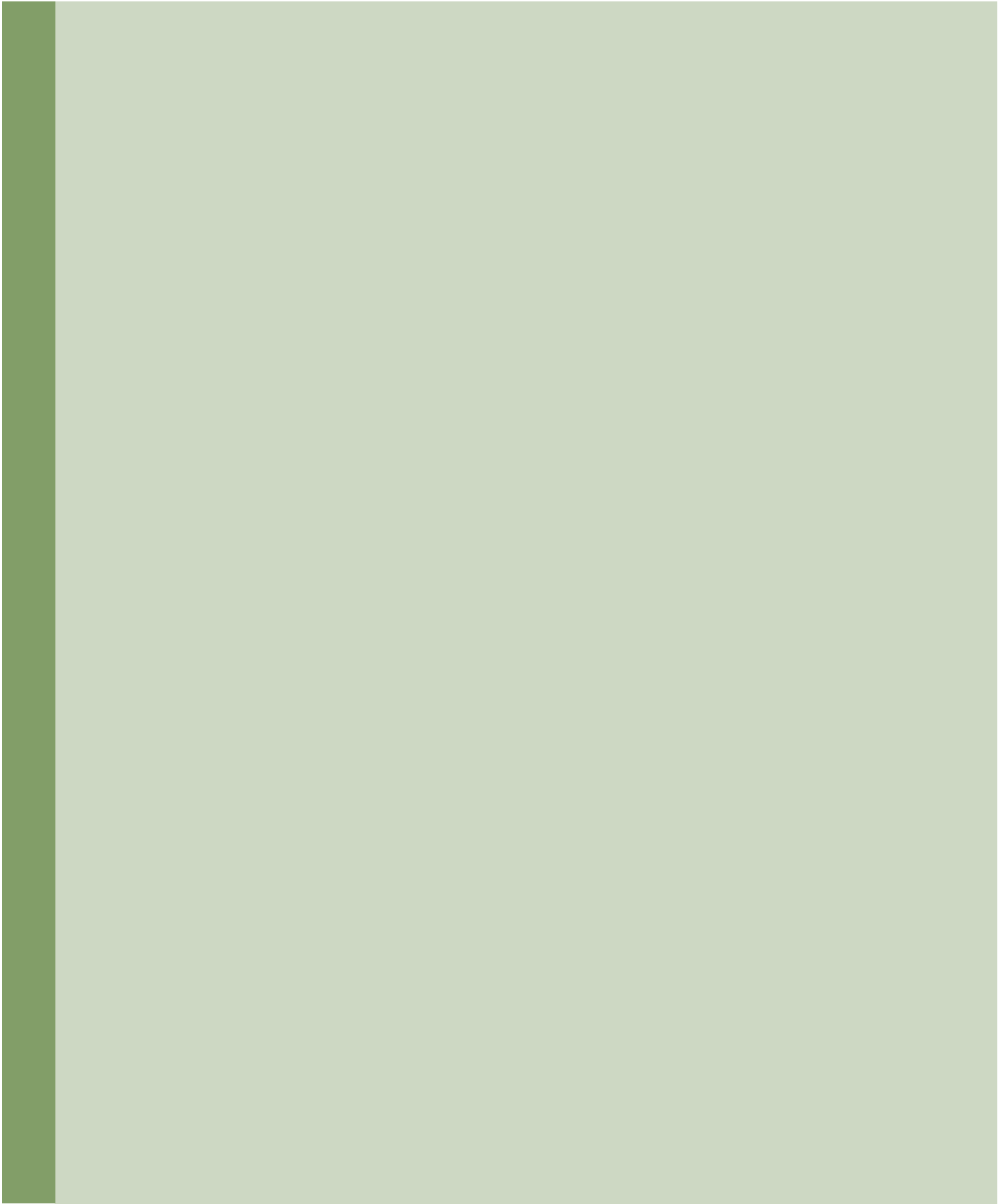
NOTE: Reconstructive surgery requires prior approval, and all inpatient admissions require MCP precertification.



Intentional misrepresentation in response to surcharge questions will have significant consequences. You will automatically lose State Health Benefit Plan coverage for 12 months beginning on the date that your false response is discovered.



DISCLAIMER: This material is for informational purposes and is not a contract. It is intended only to highlight principal benefits of the medical plans. Every effort has been made to be as accurate as possible; however, should there be a difference between this information and the Plan documents, the Plan documents govern. It is the responsibility of each member, active or retired, to read all Plan materials provided in order to fully understand the provisions of the option chosen.



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH